

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS2858HIC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/24/2008
NAME OF PROVIDER OR SUPPLIER ALMOST HOME GROUP CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 639 N ORLEANS ST HENDERSON, NV 89015		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 000	<p>Initial Comment</p> <p>This Statement of Deficiencies was generated as a result of a state licensure survey and complaint investigation conducted in your facility on 10-24-08.</p> <p>This State Licensure survey was conducted by authority of NAC 449, Homes for Individual Residential Care, adopted by the State Board of Health on November 29, 1999.</p> <p>The census at the time of the survey was two.</p> <p>There was one complaint investigated: Complaint NV00012300 was substantiated without deficiencies.</p> <p>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.</p> <p>The following regulatory deficiencies were identified.</p>	H 000		
H 019	<p>Director Duties-Qualified Caregiver</p> <p>NAC 449.15523 Director: Duties. (NRS 449.249) The director of a home shall: 4. Ensure that a caregiver, who is capable of meeting the needs of the residents and has been trained in first aid, and cardiopulmonary resuscitation, is on the premises of the home at all times when a resident is present.</p> <p>This Regulation is not met as evidenced by: Based on staff interview and record review, the</p>	H 019		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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H 019	<p>Continued From page 1</p> <p>director failed to ensure that 2 of 3 caregivers had received training in cardiopulmonary resuscitation (CPR) and first aid (Employee #2 and #3).</p> <p>Findings include:</p> <p>1. Employee #2 began working in 1999. The employee file did not contain documented evidence of a current CPR and first aid certification.</p> <p>Employee #2 revealed he had let his CPR and first aid card expire.</p> <p>2. Employee #3 began working in 2004. The employee file did not contain documented evidence of a current CPR and first aid certification.</p> <p>On 10/28/08 at 8:00am, telephone interview with the Administrator revealed Employee #3 had a recent CPR and first aid card and was attempting to receive a copy from her place of business.</p>	H 019			

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